Prevention bulletin
Publication of the Division of Public Health Services May/June 2005, Vol. 19, No. 3

New Pertussis Vaccine for Adolescents

Karen Lewis, M.D.

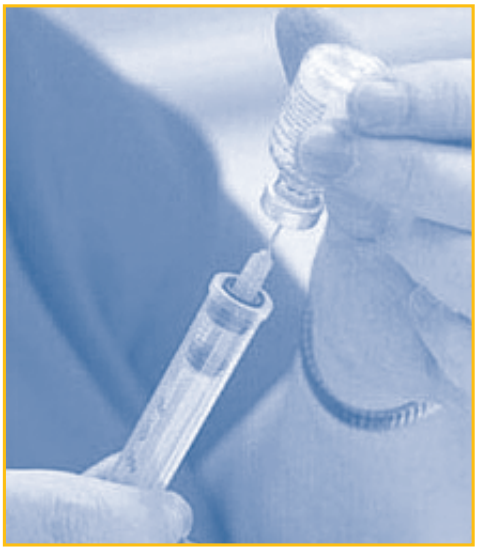
An acellular pertussis vaccine is now approved for adolescents by the Food and Drug Administration (FDA). Boostrix™ is a GlaxoSmithKline vaccine which contains acellular components of *Bordetella pertussis,* diphtheria toxoid, and tetanus toxoid. Boostrix™ is indicated as a single booster dose for ages 10-18 years old.

Another acellular pertussis vaccine (ADACEL™) has been recommended for licensure by an FDA Advisory Panel. It is expected to be approved soon for ages 11-64 years old. ADACEL™ is manufactured by sanofi pasteur.

Despite high rates of pertussis vaccination, pertussis has increased from 1,248 cases in 1981 to an annual average of 9,431 during 1996-2003.[1] In 2003, there were 11,647 cases of pertussis, the highest number reported since 1964. [2]

One reason is that pertussis vaccine immunity wears off. Adolescents and adults can be infected, even if they were vaccinated as a child. Physicians often do not consider pertussis as a cause of afebrile coughing in adolescents and adults.

During 1996-2004, most of the cases in the U.S. were in children too young to be fully immunized, or in people too old to be vaccinated. For example, 35.1% of cases were < 6 months old, and 60.7% were > 7 years old. [1].



Adolescents contribute to the pertussis burden in Arizona. In 2004, adolescents comprised 21.9% of all pertussis cases. Vaccinating this age group would decrease the spread of pertussis in schools and throughout the community.

Arizona is currently seeing a prolonged increase in pertussis cases. From January through mid May, both Pima and Maricopa Counties have reported well over 100 cases of pertussis each. Approximately 40% of the cases have been in high school and middle school students.

Boostrix™ (and when approved, ADACEL™) can be used in adolescents in place of tetanus and diphtheria toxoids (Td). This is timely in light of recent increases in pertussis cases in Arizona.

In people who have previously been fully vaccinated against tetanus and diphtheria, tetanus and diphtheria vaccines are not indicated more frequently than every 5 years, due to an increased incidence and severity of local adverse reactions. [3]

Therefore, adolescents ages 10-18 years old who have previously been fully vaccinated can be given Boostrix™ as long as it has been > 5 years since their most recent dose of tetanus and diphtheria toxoid-containing vaccine.

The Arizona State Immunization Information System (ASIIS) can help physicians to find when past doses were given. For ASIIS questions, contact the Arizona Immunization Program Office at 602.364.3899, or 1.877.491.5741.

References:

1. CDC. Outbreaks of Pertussis Associated with Hospitals—Kentucky, Pennsylvania, and Oregon, 2003. MMWR. 52 (3), 67-72.

2. CDC. Summary of Notifiable Diseases—United States, 2003. MMWR. 52 (54), 1-85.

3. CDC. Epidemiology and Prevention of Vaccine-Preventable Diseases. Atkinson W, Hamborsky J, Wolfe S, eds. 8th ed. Washington DC: Public Health Foundation, 2004, p.71.

Karen Lewis, MD, is Medical Director for Bureau of Epidemiology and Disease Control. She can be reached at 602.364.4562 or lewisk@azdhs.gov

Arizona Department of Health Services

Most Of 2004-2005 Flu Vaccine Went To High Risk Patients

by Karen Lewis, M.D.

In spite of severe influenza vaccine shortages this winter in the United States, the Centers for Disease Control and Prevention (CDC) reports that most of vaccine went to the people at greatest risk for serious complications from influenza: 6 to 23 months old children, people 65 years of age and older, and people with chronic health conditions. Influenza vaccination coverage levels among adults in priority groups were close to levels similar to previous years. Adults not in priority groups received about half of historic levels.

About 40 million doses of the 61 million doses of influenza vaccine distributed this last influenza season went to persons in the priority groups. Among adults, influenza vaccination coverage this season (through January 2005) was highest among persons aged 65 years old and older (62.7%), followed by health-care workers with direct patient contact (35.7%), and people aged 18-64 years with high-risk conditions (25.5%).

In contrast, during the 2003-04 influenza season, vaccine coverage was 65.6% in persons aged 65 years and older, 40.1% in health-care workers, and 34.2% in adults aged 18-64 years with high-risk conditions.

Healthy persons aged 18-64 years old were much less likely to have received an influenza shot during the 2004-05 influenza season. Excluding health care workers and contacts of children under 6 months of age, only 8.8 percent of healthy persons aged 18-64 years old reported receiving an influenza vaccination compared to an estimated 17.8 percent in 2003. This resulted in about 17.5 million additional doses of vaccine available this year for priority groups.

This influenza season was the first one in which influenza vaccination was recommended for children aged 6 - 23 months. For children aged 6-23 months, vaccine coverage was estimated at 48.4 percent. In contrast, during the 2002- 2003 influenza season, coverage among children aged 6 to 23 months was only 7.4 percent.

For children aged 2-17 years with high-risk conditions, vaccine coverage during the 2004-05 season was estimated at 34.8 percent. Coverage among children not in priority groups was estimated at 12.3 percent.

Karen Lewis, MD, is Medical Director for Bureau of Epidemiology and Disease Control. She can be reached at 602.364.4562 or lewisk@azdhs.gov

Reference:

1. Morbidity and Mortality Weekly Report April 1, 2005/54(12); 304-307.

2. Estimated Influenza Vaccination Coverage Among Adults and Children --- United States, September 1, 2004--January 31, 2005 *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5412a3.htm*

Some Ways To Use Up Extra Influenza Vaccine

by Karen Lewis, M.D.

Do you have unused influenza vaccine in your office? Although influenza season has gone, there are still ways to use vaccine before it expires June 30, 2005.

Consider influenza vaccine for:

- Travelers to the Southern Hemisphere during our summer (which is their winter so it is when they have influenza outbreaks).
- People going on cruises anywhere. Influenza outbreaks occur on cruise ships, even during the summer.
- Children > 6 months to < 9 years old who have never received influenza vaccine.

Infants and children from 6 months to 9 years old would be the largest potential group to whom vaccine could be offered at this point. This is because children from 6 months to 9 years old receiving influenza vaccine for the first time should receive two doses at least a month apart for optimal protection during influenza season. However, if they have received even just one dose of influenza vaccine in the past, they only need one dose in subsequent seasons.

Therefore, if you have patients who are now over 6 months old, and who will be under 9 years of age by next influenza season, and who will need influenza vaccine next fall, you can get a head start by giving them a dose of influenza vaccine now. Normally, these children would require two doses of influenza vaccine next fall. However, if they receive a dose now (before June 30, 2005), they will only need one dose of influenza vaccine next fall and in subsequent influenza seasons.

Influenza Surveillance Summary, 2004-2005

Laura Erhart, MPH

Coming on the heels of extensive efforts by providers and health departments to distribute a limited supply of influenza vaccine, influenza activity during the 2004-2005 season was mild. Influenza activity peaked in Arizona in February after an initial increase of cases in January. This temporal pattern mirrors the typical flu season in Arizona, despite the very early peak in 2003-2004. As of the beginning of April, new influenza cases continue to be identified and reported. No pediatric flu-associated deaths were reported in Arizona during the season.

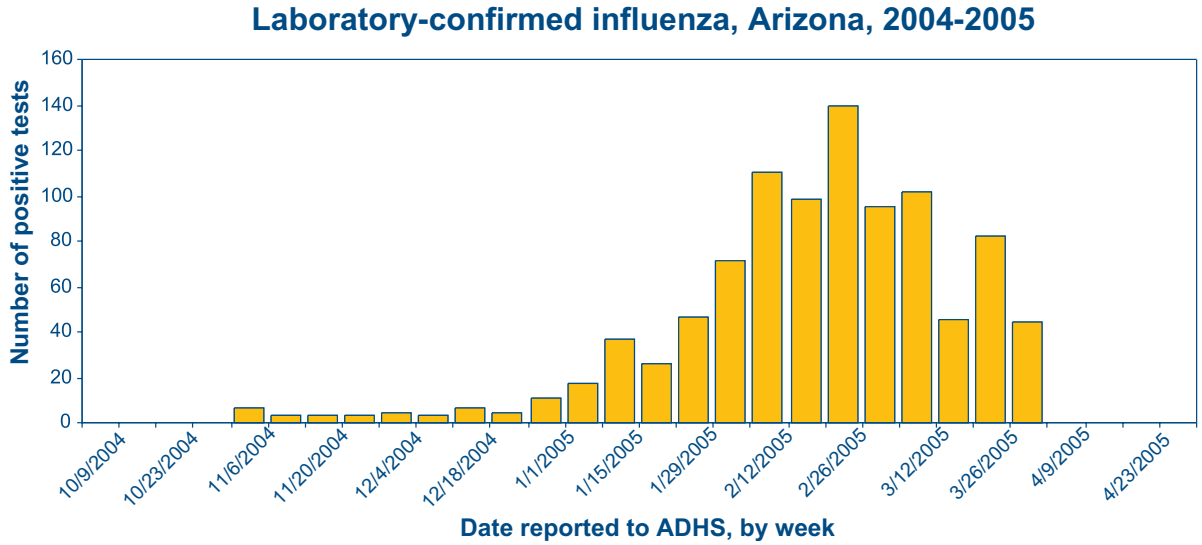
Influenza A and B viruses co-circulated throughout the Arizona flu season. The Mountain region (which includes Arizona) reported the highest proportion of influenza B isolates out of all ten CDC-designated regions, though influenza A accounted for the majority of cases regionally and nationwide. A variant of the A/Fujian strain [the A(H3N2)] vaccine component for 2003-2004) was identified in California at the end of 2004. In the following weeks, this A/California strain increased in prevalence nationally. This strain will be included in the 2005-2006 vaccine. Antigenic subtyping of Arizona specimens performed by CDC revealed that this strain circulated in the state this season.

The 2004-2005 season was the first for which influenza was reportable by laboratories, representing an additional component of Arizona's influenza surveillance. While no data were available for comparison from previous years, the timing and length of the season can be observed from the reported laboratory-confirmed cases by week of report (see figure 1 below).

Even as the season comes to a close, limited influenza surveillance must continue in order to identify any unusual events or detect novel strains imported from other sources.

Laura Erhart, MPH, is an Epidemiologist, for ADHS Infectious Disease Epidemiology Section. She can be reached at 602.364.3674 or erhartl@azdhs.gov

Figure 1



FluMist®: Start Thinking Now about the 2005-06 Influenza Season

- Begin thinking now about Health Care Worker (HCW) influenza vaccination
- FluMist® is appropriate for most HCWs
- Freezer storage requirements have been eased
- FluMist® does not contain thimerosal

CDC recommends that we begin thinking now about potential influenza vaccine availability for the 2005-06 season. Recent ACIP language more strongly emphasized the use of the live attenuated influenza vaccine (LAIV, manufactured as FluMist®) for healthy people aged 5-49 years, and also clarified that tiering of vaccine priority groups applies to inactivated (injectable) influenza vaccine only. In addition, CDC has also clarified its recommendation that most HCWs who are healthy, less than 50 years of age, and are not pregnant can get LAIV. There is one exception for use of LAIV in a HCW, a HCW who cares for severely immunocompromised patients in protected environments, such as patients who have received bone marrow transplants, or patients that have Severe Combined Immunodeficiency Disease (SCID) should not receive LAIV. For these HCWs, the injectable influenza vaccine is preferred due to a theoretical risk of transmission of the weakened live virus in LAIV to severely immunocompromised patients. If these HCW receive LAIV, they must avoid contact with severely immunocompromised patients for 7 days after receiving LAIV. To date, there have been no reports of transmission of LAIV from a HCW to any patient.

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Meningococcal Conjugate Vaccine Licensed

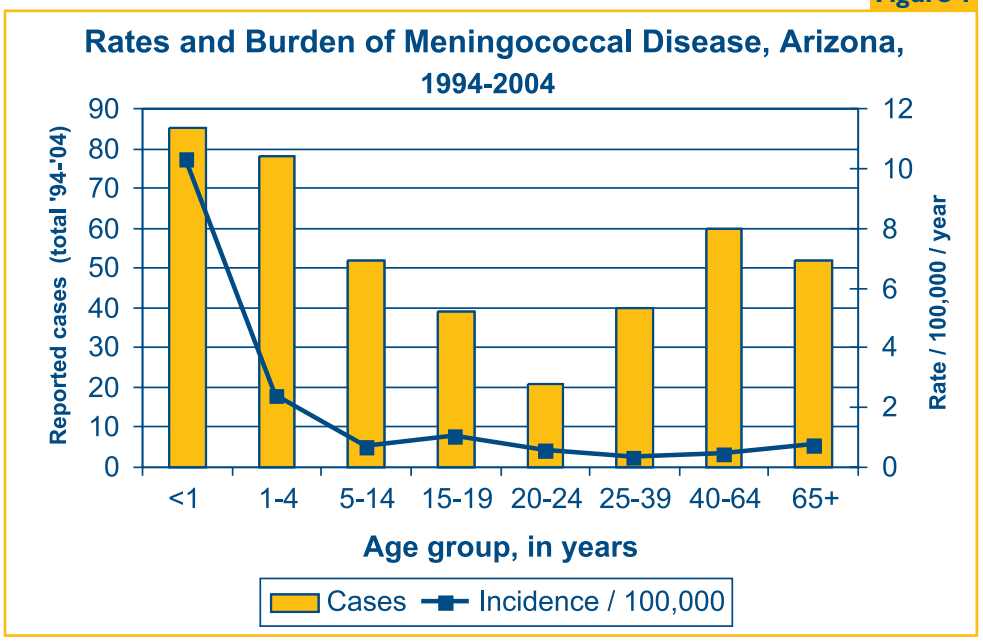
by Karen Lewis, M.D.

At the February 10-11, 2005 meeting, the Advisory Committee for Immunization Practices (ACIP) working group recommended routine vaccination with meningococcal conjugate vaccine quadrivalent (MCV4) for protection against meningococcal disease in adolescents and adults aged 11-55 years. Meningococcal disease is caused by bacteria that infect the bloodstream, lining of the brain and spinal cord, often causing serious illness. Every year in the U.S., 1,400 to 2,800 people contract meningococcal disease. Ten to 14 per cent die and 11-19 percent have permanent disabilities such as mental retardation, hearing loss and loss of limbs.

ACIP recommended the vaccine at pre-adolescent visits (11-12 year olds) or high school entry (15 year olds); college freshmen living in dorms, and other groups at highest risk (military recruits, travelers to or residents of countries experiencing epidemic disease, microbiologists at risk). A catch-up campaign was not recommended. MCV4 will be preferred for all persons aged 11 – 55 years old, although MPSV4 (meningococcal polysaccharide vaccine quadrivalent) is acceptable.

Recommendations for control of outbreaks are unchanged from prior recommendations. Persons vaccinated with MPSV4 should be re-vaccinated after 3-5 years if they remain at risk. No recommendation was made on re-vaccination of recipients of MCV4, pending observations over the next 5 years. These recommendations were unanimously accepted by the full ACIP.

Figure 1



The vaccine was licensed by the U.S. Food and Drug Administration (FDA) on January 14, 2005, is manufactured by Sanofi Pasteur and will be marketed as Menactra™. The vaccine is highly effective. However, it does not protect people against meningococcal disease caused by "type B" bacteria. This type of bacteria causes one-third of meningococcal cases. More than half of the cases among infants aged <1 year are caused by "type B," for which no vaccine is licensed or available in the United States.

The vaccine is recommended for these groups:

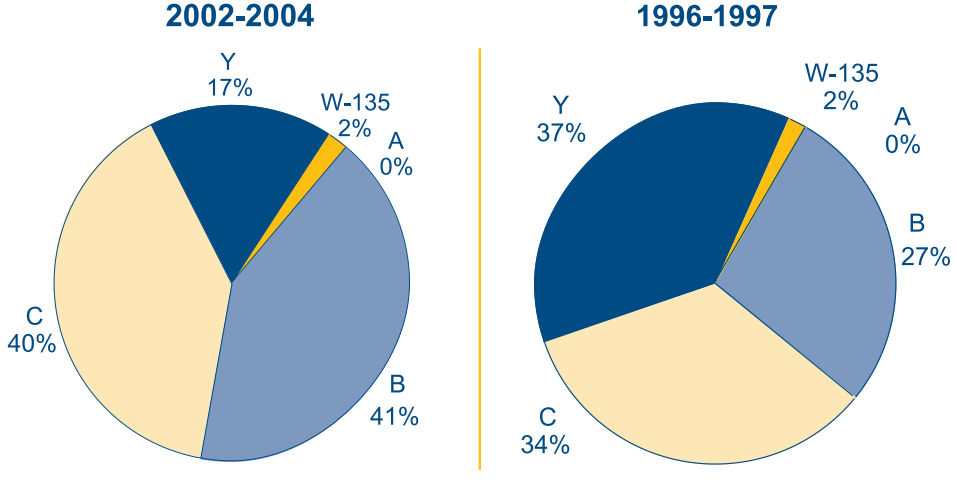
Adolescents aged 11-18 years traveling to countries in which meningococcus is hyperendemic or epidemic, particularly if contact with the local population will be prolonged.

- Adolescents aged 11-18 years with terminal complement deficiencies and those with anatomic or functional asplenia.
- Adolescents aged 11-18 years who are infected with HIV
- Adolescents 11-12 years old at their preadolescent assessment visit.
- Adolescents at high school entry (aged 15 years) who were not vaccinated at the preadolescent visit.
- College freshmen living in dormitories.

MCV4 should be administered 0.5mL intramuscularly (IM). There is no recommendation for revaccination but this may change pending observations over the next 5 years.

Arizona specific data on meningococcal disease is illustrated in the charts shown in Figures 1 & 2.

Figure 2



Karen Lewis, MD, is Medical Director for Bureau of Epidemiology and Disease Control. She can be reached at 602.364.4562 or lewisk@azdhs.gov

Healthcare Associated Streptococcal Toxic Shock Syndrome in Coconino County

by Clare Kioski, MPH

Two cases of Streptococcal Toxic Shock Syndrome were reported in a Coconino County healthcare facility in February, 2005. Pulsed Field Gel Electrophoresis (PFGE) of the isolates at the Arizona Public Health Laboratory (APHL) indicated that these isolates were genetically related. Subsequently, the isolates were sent to the Centers for Disease Control and Prevention (CDC) for M protein gene (emm) typing. The CDC uses a sequence-based system to determine the emm gene which encodes the cell surface M virulence protein. Both case isolates belong to the emm type group 1.0, a relatively common emm type among invasive streptococcal strains. These isolates were further subtyped at CDC and were identified as emm1.6, a rare subtype in the United States.

The initial case was hospitalized at a healthcare facility with necrotizing fasciitis of the leg and streptococcal toxic shock syndrome (STSS). Her leg was amputated at the hip due to the infection. The second case was a respiratory therapist employed by the health care facility who was admitted to the same facility eight days after the initial case was admitted. He was diagnosed with pneumonia and streptococcal toxic shock syndrome. He had cared for the initial case several days after the patient was removed from contact precautions. Both cases survived.

Given the potential transmission in the healthcare facility and upon consultation with the CDC and the Arizona Department of Health Services (ADHS), the healthcare facility obtained throat swab specimens and questionnaires on all contacts of these cases. Those with Group A Streptococcus (GAS) isolates were given prophylactic antibiotics (azithromycin) to prevent invasive disease. Contacts of any GAS positive contacts also had throat swabs obtained. All GAS isolates were analyzed by PFGE and compared to the STSS case strain. Isolates were also sent to CDC for emm typing.

Arizona averages 248 cases of invasive GAS infections every year. In 2004, there were 262 cases of invasive GAS infection in Arizona.

Throat swabs were obtained from 704 individuals who may have had contact with these two recent cases. Twenty-one of these "contacts" (2.9%) were positive for GAS. None of these contacts were symptomatic for pharyngitis. Only one of the 21 matched the STSS case strain and emm type. This individual does not provide patient care and actually did not have contact with either case and was sampled inadvertently. The period of increased risk for secondary cases of invasive GAS disease is in the first 30 days after exposure. No further cases of invasive GAS occurred during this time period.

Two isolates from previous cases of invasive GAS from Coconino County, one each from 2000 and 2002, were tested to determine if they were related to the 2005 STSS case strain. There was not a match between the 2000 and 2005 isolates. However, the 2002 isolate matched the 2005 STSS strain by PFGE and was further identified to be emm type 1.0. The person with the 2002 isolate died of Streptococcal Toxic Shock Syndrome.

It is of interest, that the 2005 invasive GAS isolates were indistinguishable from the asymptomatic individual, who did not have apparent contact with either case, as well as being indistinguishable by PFGE from the 2002 fatal case. This suggests that this subtype of GAS circulates in the community and has been circulating over the last few years, and may only rarely manifests itself as invasive disease.

Arizona averages 248 cases of invasive GAS infections every year. In Arizona in 2004, there were 262 case of invasive GAS infection.

The APHL has now developed the capability to perform emm typing of invasive GAS isolates. This laboratory technique will allow for improved investigation of unusual GAS infections.

Reference:

Prevention of Invasive Group A Streptococcal Disease among Household Contacts of Case Patients and among Postpartum and Post-surgical Patients: Recommendations from the Centers for Disease Control and Prevention. CID. 2002:35 (15 October) 950-959.

Clare Kioski, MPH is an Infection Control Epidemiologist and can be reached at 602.364.3675 or kioskic@@azdhs.gov.

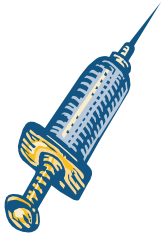
FluMist® continued from page 3

Storage requirements for FluMist® have been changed. In November 2004 the requirement for the hard plastic freezer storage box supplied by the manufacturer was eased, and storage of FluMist® in a freezer at –15° Celsius or colder is now required. Storage of FluMist® in a frost-free freezer is also allowed, as of November 2004.

Given the injectable influenza vaccine shortage during the 2004-05 season, consideration of FluMist® for HCW who meet eligibility criteria may be a decision point to ponder early in the planning process. For more information go to this website: *http://www.cdc.gov/flu/professionals/flugallery/images04_05/FluMistQA.pdf.*

Noteworthy

Varicella Vaccination Requirement Coming This Fall



ADHS anticipates approval of a varicella vaccination requirement this June by the Secretary of State's Office. Children attending childcare, Kindergarten, 1st and 7th grades will be required to show proof of immunization or parental history of disease. This requirement will be effective in Fall 2005. Providers should make sure these patients receive a varicella vaccination or have documented history of varicella (chickenpox) disease.

Contracts Awarded

The Arizona Department of Health Services has awarded $360 million in three contracts for the provision of mental health services outside of Maricopa County.

The winners of the contracts are: Northern Arizona Regional Behavioral Health Authority (NARBHA) , Community Partnership of Southern Arizona (CPSA), and Cenpatico Behavioral Health. NARBHA and CPSA are current holders of contracts, which cover geographic service areas (GSA) 1 (Apache, Coconino, Mohave, Navajo, and Yavapai Counties), 3 (Cochise, Graham, Greenlee, and Santa Cruz Counties) and 5 (Pima County). Cenpatico Behavioral Health is a new contractor and will assume the administration of services provided in GSAs 2 (La Paz and Yuma Counties) and 4 (Gila and Pinal Counties). All services under the new contracts, must meet the needs of people with mental illness, including easy access to services; consumer and family involvement; collaboration with the greater community; effective innovation; and cultural competency. As of January 2005, there were 58,301 adults and children receiving behavioral health services outside of Maricopa County. For more information on mental health services in Arizona, please visit the ADHS website at *http://www.azdhs.gov.*

Physician Signature on Electronic Death Certificates

You Have Heard the Rumors . . .

Over the last six or seven years, you have heard rumors that the Office of Vital Records is going electronic. You have heard that physicians will be able to digitally sign death certificates. You have heard that funeral directors will no longer be chasing you down in hospitals and interrupting your practice to get your signature on a death certificate. Like the boy who called wolf, you have heard it for so long, and so often, you don't believe it any more. Well, believe it.

For several weeks, the Office of Vital Records has had a consultant developing the requirements for this new electronic system. In fact, birth certificates, fetal death certificates and death certificates will all be electronic records in a matter of months.

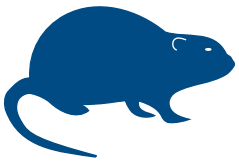
The requirements will become part of an RFP (Request For Proposal) that we expect to issue by June to select a vendor for the system design and development. We should have a contract awarded by September, and we will have the system built, tested and in place, and begin rolling it out to all of our partners (you included) some time in 2006.

As certifying physicians, you will find this very convenient. In addition to the advantages listed above, you will be able to log into the system from any computer with a secure Internet connection. When you log in, you will see a screen that will tell you if you have a death certificate in your queue, go to that record, enter the causes and manner of death and digitally sign the certificate. You're done! You will be able to do this at a time and place convenient to you. We anticipate many hospitals, clinics, hospices, etc., will have computers set up in convenient locations that you can use for this purpose.

Watch for more information as we move closer to making this a reality.

Confirmed Hantavirus Pulmonary Syndrome (HPS) Case

The Department announced the first confirmed hantavirus pulmonary syndrome (HPS) case in the state in April. The patient appears to have been exposed in the northern part of the state, although it is likely that the risk of exposure to hantavirus is higher this year throughout the state. Physicians are reminded to consider hantavirus as a potential etiology for patients experiencing severe respiratory distress and who have reported exposure to rodents, rodent droppings or their nests.



Clinical findings may include a prodromal history of fever, myalgias, malaise, and nausea. Prodrome (avg. 4-5 days) is typically followed by onset of respiratory symptoms, including dry cough and dyspnea, which may progress into pulmonary edema and hypoxemia within a few hours. Initial chest X-rays may reveal signs of interstitial edema. As HPS progresses, alveolar flooding occurs in the basilar or perihilar areas rather than the peripheral pattern typically seen with ARDS. Pleural effusions are also seen as the disease progresses. Laboratory findings commonly include an elevated hematocrit, thrombocytopenia, and leukocytosis with a left shift. At least 10% of lymphocytes are either immunoblasts or plasma cells.

Serologic testing for HPS is available at the Arizona State Health Laboratory (ASHL). See previous Prevention Bulletin or contact Craig Levy at 602.364.4562 for consultation or more information on HPS.

SUMMARY OF SELECTED REPORTABLE DISEASES

Year to Date (January - March, 2005)[1, 2]

	Jan - Mar 2005	Jan - Mar 2004	5 Year Median Jan - Mar
VACCINE PREVENTABLE DISEASES:			
Haemophilus influenzae, serotype b invasive disease (<5 years of age)	0 (0)	0 (0)	2 (1)
Measles	1	0	0
Mumps	0	0	0
Pertussis (<12 years of age)	55 (23)	26 (13)	24 (13)
Rubella (Congenital Rubella Syndrome)	0 (0)	0 (0)	0 (0)
FOODBORNE DISEASES:			
Campylobacteriosis	172	142	116
E.coli O157:H7	5	4	4
Listeriosis	3	2	4
Salmonellosis	149	163	131
Shigellosis	63	96	87
VIRAL HEPATITIDES:			
Hepatitis A	69	80	104
Hepatitis B: acute	81	53	54
Hepatitis B: non-acute	277	256	308
Hepatitis C: acute	0	0	1
Hepatitis C: non-acute (confirmed to date)	2,317 (720)	2,853 (975)	2,272 (979)
INVASIVE DISEASES:			
Streptococcus pneumoniae	221	253	324
Streptococcus Group A	86	85	68
Streptococcus Group B in infants <90 days of age	13	11	8
Methicillin-resistant *Staphylococcus aureus*[3]	280	N/A	N/A
Meningococcal Infection	11	4	13
SEXUALLY TRANSMITTED DISEASES:			
Chlamydia	5,369	4,414	3,343
Gonorrhea	1,130	1,279	1,082
P/S Syphilis (Congenital Syphilis)	35 (4)	41 (2)	41 (7)
DRUG-RESISTANT BACTERIA:			
TB isolates resistant to at least INH (resistant to at least INH & Rifampin)	2 (0)	1 (0)	1 (0)
Vancomycin resistant *Enterococci* isolates	434	357	256
VECTOR-BORNE & ZOONOTIC DISEASES:			
West Nile virus Infection	0	0	N/A
Hantavirus Pulmonary Syndrome	0	0	0
Plague	0	0	0
Animals with Rabies[4]	50	15	15
ALSO OF INTEREST IN ARIZONA:			
Coccidioidomycosis	645	870	651
Tuberculosis	24	42	29
HIV	167	117	127
AIDS	124	112	118

1 Data are provisional and reflect case reports during this period.
2 These counts reflect the year reported or tested and not the date infected.
3 MRSA was not reportable before October 2004.
4 Based on animals submitted for rabies testing.

Data compiled by Offices of Infectious Disease and Office of HIV/AIDS Services

Prevention bulletin

Arizona Department of Health Services

Arizona Department of Health Services
Public Information Office
150 North 18th Avenue
Phoenix, AZ 85007

Janet Napolitano, Governor
Susan Gerard, Director ADHS
Rose Conner, Assistant Director, Public Health Services

Contributors

Laura Erhart, Karen Lewis, the Office of Infectious Disease Services, the Arizona Immunization Program Office and the Office of HIV/AIDS Services

Managing Editor: Mary Ehlert, M.S., ABC
e-mail: ehlertm@azdhs.gov

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Clinical Lab Rulemaking Notice

The Arizona Department of Health Services has filed a Notice of Proposed Exempt Rulemaking and Notice of Public Information for Title 9, Chapter 14, Article 1 of the Arizona Administrative Code.

Arizona Revised Statutes (A.R.S.) § 36-466, as added by Laws 2004, Chapter 49, § 1 (HB 2046), established the Advisory Committee on Clinical Laboratories (ACCL). At public meetings on January 10, 2005, and February 2, 2005, the ACCL approved a list of direct access tests and standards for the use of laboratory standing orders.

Arizona Revised Statutes § 36-466(D) requires the ADHS to make rules based on the ACCL's recommendations. According to Laws 2004, Chapter 49, § 3, the ADHS is exempt from the rulemaking requirements of A.R.S. Title 41, Chapter 6, until August 25, 2005.

The ADHS filed with the Secretary of State a Notice of Proposed Exempt Rulemaking and a Notice of Public Information. These notices are published in the Arizona Administrative Register for April 22, 2005. The notices are available at the Secretary of State's website at *www.azsos.gov/aar/2005/17/contents.shtm* or by link from the ADHS Office of Administrative Rules website at *www.azdhs.gov/diro/admin_rules/exempt.htm* under Division of Public Health Services, Laboratories - Direct Access Tests and Laboratory Standing Orders.

The Notice of Proposed Exempt Rulemaking contains the proposed rules on direct access tests and laboratory standing orders and schedules a May 31, 2005 public hearing on the proposed rules. The Notice of Public Information also informs the public about the public hearing at 10:00 a.m., May 31, 2005, at 1740 W. Adams, Phoenix, AZ 85007, Room 411.

You can submit written comments on the proposed rules until 5:00 p.m., May 31, 2005 to:

Lynn Golder, Rules Analyst
Arizona Dept. of Health Services
1740 W. Adams, Suite 202
Phoenix, AZ 85007
Telephone: (602) 364-3958
Fax: (602) 364-1150
E-Mail: golderl@azdhs.gov

The ADHS looks forward to your comments on the proposed rules for direct access tests and laboratory standing orders.